DEPARTMENT OF HEALTH AND SOCIAL SECURITY
WELSH OFFICE

CENTRAL HEALTH SERVICES COUNCIL

The Functions of the District General Hospital

REPORT OF THE COMMITTEE

LONDON
HER MAJESTY'S STATIONERY OFFICE
THREE SHILLINGS NET

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1969

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Prefatory note by the Secretary of State for Social Services and the Secretary of State for Wales

This report, which has been submitted to us by the Central Health Services Council, should help to stimulate discussion of the future pattern of an integrated health service. Before conclusions can be reached on its findings and recommendations, they will have to be further considered in the light of the likely future pattern of community health and social services. In particular a lot more thought must be given to the best way of providing for people who need long-term care, and also to the functions of smaller hospitals supplementary to the district general hospitals.

Other important points which need consideration are: what variations in the pattern of hospital services are needed to take account of varying distribution of population and availability of sites; the time it would take to realise a new pattern; and the hospital services to be maintained in the intervening period.

RICHARD CROSSMAN
GEORGE THOMAS

Foreword by the Central Health Services Council

The attached Report by the Committee on the Functions of the District General Hospital was considered by the Council at their meeting on 14th January, 1969, and was then referred to the Standing Medical, Nursing, Mental Health and Maternity and Midwifery Advisory Committees for their comments. These having been received, the Council considered the Report again at their meeting on 15th April, 1969, in the presence of the Minister of State (Baroness Serota), and decided to submit the Report to the Secretaries of State with the following observations:

(1) The terms of reference and composition of the Committee, and the evidence they took from representatives of Medical Officers of Health and of general practitioners, make it clear that their Report should not be seen as only a report about district general hospitals, but as one about the part that district general hospitals should play within the National Health Service as a whole. Indeed the Committee's recommendations assume the need for a corresponding development of the community services, both in quality and in quantity.

(2) Recognising that in the more sparsely populated areas the concentration of diagnostic and acute treatment services into fewer and larger district general hospitals raises problems of their communications with and accessibility to general practitioners, to the other community services and above all to patients and their relatives and friends, the Council would draw attention to the potentially important complementary role of the "peripheral hospital units" discussed in paras. 32–39 of the Report.

(3) The Council recognise that the Committee's recommendations would take many years to implement in full even on the assumption that the difficulties of finding suitable hospital sites can be overcome; they further recognise that in a number of areas planning in accordance with current policy will have advanced so far that it cannot without unacceptable delay and loss of momentum be radically changed; nevertheless they believe that it is important that it should be commended to the hospital service as a statement of broad principles on which future planning should be based.

REPORT

INTRODUCTION

1. At their meeting on 11th January, 1966, the Central Health Services Council listened to talks by Dr. J. O. F. Davies (then Senior Administrative Medical Officer, Oxford Regional Hospital Board) and Professor T. McKeown (Professor of Social Medicine, University of Birmingham) about the district general hospital. In the discussion that followed there was general agreement that the functions of the district general hospital should be reconsidered. It was therefore decided to set up a Committee of the Council with the membership as shown on page ii.

2. The Committee proposed, and the Council confirmed, the following terms of reference:

> "To consider the concept of the district general hospital promulgated in 1961–62, in the light of developments since that time; and to redefine the functions which the district general hospital should perform in the health service of the future."

3. The Secretary to the Committee was Mr. J. A. W. McDonald of the Ministry of Health/Department of Health and Social Security, assisted by Mr. M. P. Silverman (until December 1967) and Mrs. K. F. Savage (thereafter). Other officers of the Ministry of Health/Department of Health and Social Security and of the Welsh Board of Health attended the Committee's meetings by invitation. We wish to place on record our sincere appreciation of their work and of the patience which they have shown towards us, individually and collectively, at all times during the last three years. It is no easy task for a Secretary and his colleagues to keep the balance between their duty to their Committee and their loyalty to the officers of their Department whose knowledge and experience often cause them to hold—and press forward their own strong views. This balance has been held admirably.

4. The full Committee met ten times in all, but for the initial consideration of written evidence we divided into two sub-committees, which met three times and twice respectively. Also we later sub-divided into smaller groups to receive oral evidence, which took up five days and parts of two others. A list of the organizations and individuals who gave written and/or oral evidence is at Appendix B.

5. Our present Report has been revised to take account of comments received from the Standing Medical, Nursing, Mental Health, and Maternity and Midwifery Advisory Committees and from members of the Council itself.

ORIGINS OF THE CONCEPT OF THE DISTRICT GENERAL HOSPITAL

6. The idea of the district general hospital, incorporating provision for all the ordinary acute general specialties, can be traced to the Hospital Survey

undertaken during the Second World War.* In the early post-war years, however, very little could be done towards building new hospitals; it was not until the end of the 1950s that a major programme of hospital building got under way. We understand that the first few major schemes were planned on an *ad hoc* basis.

7. It was in the early 1960s, with the preparation of the first Hospital Plan, that the time came to formulate the concept of the district general hospital, first in the Ministry of Health's Building Note No. 3 (1961) and then in the Hospital Plan itself,† which said:

> "In recent years there has been a trend towards greater interdependence of the various branches of medicine and also an increasing realisation of the need to bring together a wide range of the facilities required for diagnosis and treatment. Hence the concept of the district general hospital which provides treatment and diagnostic facilities both for in-patients and out-patients and includes a maternity unit, a short-stay psychiatric unit, a geriatric unit and facilities for the isolation of infectious diseases. Provision is made for all other ordinary specialties, but there are a small number of specialties, such as radiotherapy, neurosurgery, plastic surgery and thoracic surgery which need a larger catchment area and would be provided only at certain hospitals. The size of hospital this concept implies would normally be of 600–800 beds serving a population of 100,000–150,000. Some district general hospitals, particularly where more specialties are provided, might be larger. Others would be smaller, though they would rarely be of less than about 300 beds. Each would be located in or near the centre or one of the centres of population of the area which it serves. The district general hospital offers the most practicable method of placing the full range of hospital facilities at the disposal of patients and this consideration far outweighs the disadvantage of longer travel for some patients and their visitors."

It was stated that most, but not necessarily all, district general hospitals would contain a fully developed accident and emergency department.

8. The plan envisaged that separate hospitals would continue to be maintained or provided in the following roles:

(*a*) long-stay geriatric annexes;

(*b*) some of the existing mental illness hospitals (mainly for long-stay cases);

(*c*) mental subnormality hospitals;

(*d*) small hospitals in peripheral towns (for normal maternity cases, long-stay geriatric cases, some medical cases, and out-patient clinics).

9. This concept of the district general hospital was endorsed in the last published review of the Hospital Plan* and has remained official doctrine pending our report. We are, however, aware that current hospital planning to some extent anticipates what we have to say.

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* e.g. *Hospital Survey—the Hospital Services of London and the surrounding area*, written by Dr. A. M. H. Gray and Dr. A. Topping and published for the Ministry of Health by H.M.S.O. in 1945, at p. 20.

† *A Hospital Plan for England and Wales*, Cmnd. 1604, January 1962, at p. 6, para. 20.

‡ *The Hospital Building Programme*, Cmnd. 3000, May 1966, at p. 4, para. 13.

GENERAL APPROACH

10. The evidence we received confirmed that the concept of the district general hospital set out in the original Hospital Plan is largely accepted, but that the following main aspects required our attention:

(*a*) whether it is satisfactory for the hospital services provided for psychiatric patients (including the mentally subnormal) and for geriatric/chronic sick patients to be partially, but not fully, integrated into the district general hospital;
(*b*) the optimum size of population to be served by the district general hospital;
(*c*) the range of acute specialties for which in-patient services should be provided in every district general hospital;
(*d*) the extent to which hospital services should continue to be provided at small hospitals in peripheral towns;
(*e*) the district general hospital's relationship with the community services, including general practitioners.

These are largely inter-related, so that the following reasoning is inevitably rather complex.

11. Perhaps we should begin by discussing the essential function of the hospital component of a comprehensive health service for the population of a defined area; we see this as being to provide those medical, para-medical and nursing services which, either because of the specialised skills and equipment or because of the degree of care required, cannot economically be provided in the patient's own home or at the health/group practice centres in the community (see paras. 40–46 below). It is now generally accepted, and we are ourselves convinced, that this function can more efficiently and effectively be performed by a comprehensive district general hospital than by a number of separate hospitals each with limited functions. Not merely can supporting services be more economically provided at one central site (see para. 22), but the patient who may be suffering from a combination of different conditions should not have to be referred from one hospital to another: he should ideally be able to obtain whatever hospital treatment he requires from a team of consultants working together in the one district general hospital. (We say "ideally" only because there are certain highly specialised forms of treatment—see para. 30—for which it is not possible to provide in every district general hospital.)

12. We therefore do not favour any further development of separate children's, women's, accident, orthopaedic, or other single-specialty hospitals: we rather consider that these services should be provided at district general hospitals in children's departments, maternity and gynaecological departments, and accident and orthopaedic departments. (The children's department should be a comprehensive one, including adequate provision for assessment* as well as for in-patient care, and should be staffed by doctors, nurses, teachers, etc. qualified to work with sick children; all child patients should come to this department.) We would however concede that in the major conurbations and cities not every district general hospital need include a department of each of these types: for in these areas the advantages of concentrating these services into

* As recommended by the Working Party on Comprehensive Assessment Centres for Handicapped Children in their unpublished Report.

larger units may perhaps outweigh the disadvantages (notably in the recruitment and training of staff) of limiting the range of service which the individual district general hospitals can give to the districts they serve.

13. We should perhaps include something here about the undergraduate *teaching hospitals*. We have noted with interest the recommendations of the Royal Commission on Medical Education,* and in particular their endorsement of the view that undergraduate teaching hospitals ought to carry district responsibilities (paras. 373 and 496). We for our part accept that these hospitals will continue to draw some patients from outside their allotted districts, and may well include various special units providing a regional service (see paras. 28–30 below).

INTEGRATION OF THE HOSPITAL PSYCHIATRIC AND GERIATRIC SERVICES

14. The 1962 Hospital Plan† implied partial, but not complete, integration of the *mental illness* and *geriatric* hospital services into the district general hospital: each of these was normally to include a short-stay psychiatric unit and an active geriatric unit, but some provision for long-stay cases was to be retained (or made) elsewhere. But after much discussion among ourselves and with representatives of the various professional associations concerned we have concluded that to divide either of these two services between the district general hospitals and other specialist hospitals is fundamentally unsatisfactory. We think it has now been demonstrated beyond doubt that a district general hospital mental illness unit can accept almost every type of mentally ill patient (though special facilities may need to be provided perhaps at selected district general hospitals only, for some groups such as drug addicts and alcoholics) and that there are substantial advantages (both to patients and to staff) in basing the hospital treatment of mentally ill and geriatric patients in the district general hospital with all its comprehensive facilities. We are therefore convinced that all hospital treatment of mental illness, and all hospital geriatric treatment ought eventually to be based on district general hospitals. We accept that there may be some patients who after all the appropriate specialist treatment will still need to be accommodated in a hospital environment rather than in the community, but we propose that these should be accommodated either in the district general hospital or (see paras. 33–39 below) in peripheral hospital units nearer to their homes. It follows that in our view all the existing mental illness and geriatric/chronic sick hospitals, except those which are so sited that they can be integrated into district general hospitals or converted into peripheral hospital units, must eventually close.

15. *Mental subnormality*. The 1962 Hospital Plan said:§

"Beds for subnormal and severely subnormal patients do not need to be at the district general hospital. Subnormal patients should be cared for separately from the severely subnormal and in comparatively small units, preferably of not more than 200 beds, which are best located in areas where after training the patients can be employed and so eventually may return to the community. Severely subnormal patients should be cared for in separate hospitals except

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* *Report of the Royal Commission on Medical Education, 1965–68.* Cmnd. 3569, April 1968.
† Ibid, paras. 20, 24 and 27 on pp. 6–8.
§ Ibid, at p. 8, para. 28.

that severely subnormal children who suffer from physical handicap can be looked after in a separate ward of the paediatric unit at a district general hospital."

Reference was made* to the prospect of continued expansion of the community services (including training centres, residential hostels and facilities for sheltered employment) as a factor which would avoid or postpone the need for hospital admission in many cases, and enable more patients to be discharged.

16. Our approach to the care of the mentally subnormal shares common ground with that set in respect of the mentally ill in paragraph 14 above. While there are still some who consider that a separate subnormality hospital offers the best environment for long term care, this seems to be increasingly questioned. We for our part cannot accept that it is in the interest of the mentally subnormal themselves or of the staff who provide for their treatment and care that these should be provided under conditions which segregate them from the mainstream of medicine. Moreover we have found considerable support for the view that initial assessment and reassessment should be undertaken at the district general hospital by a multi-disciplinary team of psychiatrists, paediatricians, neurologists and other specialists concerned with associated handicaps. Similarly, some mentally subnormal persons exhibit disorders of behaviour or suffer from mental illness; we consider that these would best be dealt with by the district general hospital psychiatric unit. For those mentally subnormal persons who really require intensive specialist medical and nursing care as in-patients, we think the best environment would be the appropriate specialist department (e.g. paediatric, orthopaedic or psychiatric) or purpose-built accommodation on the district general hospital site, with shared use of all its relevant services.

17. A considerable proportion† of those now resident in hospitals for the mentally subnormal should we think eventually be discharged to community care, though this will be possible only provided that community services for the subnormal are developed on a considerably larger scale than hitherto and are closely co-ordinated with those provided by the hospital service. Some of those to be discharged could return to their families, provided that arrangements are made for short term readmission to hospital when necessary. Others could best be placed (according to age) in residential nurseries, residential training schools, hostels and homes. However, the mentally subnormal will in the future pose new problems for the National Health Service and the other social services. The incidence at birth of conditions leading to severe mental subnormality and other forms of handicap is probably falling, but on the other hand more severely subnormal persons are even today surviving to adolescence and adult life. Moreover, experience with residential "community" services of various sorts for the mentally subnormal is still very limited, and there is a division of opinion as to the proportion of patients whom it will be possible to transfer to the community services, and the proportion who will still need to have specialist hospital care. There is likely therefore to be a continuing need for hospital accommodation specially designed for the long term care of those subnormal patients whose nursing needs are less intensive and for whom special

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* Ibid, at p. 12, para. 42.

† In their paper "Institutional Care of the Mentally Subnormal" published in the *British Medical Journal* on 2nd September, 1967, Professor T. McKeown and Dr. I. Leck argued that only about half of the patients in hospitals for the mentally subnormal in the Birmingham area needed the kind of care which made it necessary for them to be in hospital.

occupational and training facilities are required. Such accommodation should in our view be sited where it will allow patients to share in activities of the community to the maximum extent possible. Where the catchment area of the district general hospital is reasonably compact accommodation of this kind might be provided at the district general hospital nearby. Alternatively, accommodation might be provided in smaller units situated conveniently to the areas from which the patients are drawn, and either specially designed or forming part of the peripheral hospitals discussed in paragraphs 33–39. In all cases, however, we consider that these units for the subnormal should be closely linked to the district general hospital and should come under the same clinical control.

18. *The younger "chronic sick"*. There is one other category of patient (not specifically allocated in the Hospital Plan) about whose inclusion in the district general hospital there may be some doubt: the severely physically handicapped or "chronic sick" young adult, adolescent or child in need of skilled nursing care and/or medical treatment not available at home or in the community. We do not favour the perpetuation of separate long-stay hospitals or nursing homes for such patients; we consider that they will best be cared for if grouped together in special units attached to district general hospitals. But a recent survey by the Department has shown that there are not very many such patients; so if they are to be grouped together in special units these can be provided only at selected district general hospitals. It follows that the other district general hospitals should be prepared to provide individual care for any such patient who may prefer to remain near their relatives.

OPTIMUM SIZE OF POPULATION TO BE SERVED

19. The Hospital Plan and associated publications did not explain how the norm of 600–800 beds, serving 100,000–150,000 population, had been derived. We understand, however, that at one time 800 beds was considered to be the maximum for any hospital in an urban area, on Civil Defence grounds; and we appreciate that 600–800 beds is considerably larger than most existing general hospitals. Nevertheless, we have become convinced that this range of size, or rather the associated range of size of population served, is too small. Our analysis of the relevant factors follows.

—CONSULTANT STAFFING

20. The 1945 Hospital Survey* spelt out in some detail the content of a typical district general hospital in terms of beds and consultant staffing: in some of the smaller acute specialties for which in-patient provision was to be included (e.g. ophthalmology and ear, nose and throat surgery) there was to be the equivalent of only one, or even less than one, whole-time consultant. This feature was implicit also in the Hospital Plan and its associated publications, and has become explicit in most of the district general hospitals so far built or now under construction. But it has been urged on us in evidence from a wide range of witnesses, and we accept, (*a*) that it is not desirable that any consultant should work on his own, and thus without frequent contact with colleagues in his specialty and without cover at consultant level when off duty or absent; and

* Loc. cit.

(*b*) that no consultant in an acute specialty can be in effective charge of the treatment of in-patients at a hospital which he visits only from time to time—we consider that daily visiting (with at least four sessions a week) is essential, and that ideally no consultant in an acute specialty should be in charge of in-patients at more than one hospital. It follows that in each acute specialty in which in-patient work is undertaken at the district general hospital, the medical staff ought to be headed by a team of at least two consultants with (ideally) all their in-patients concentrated at that hospital.

21. Appendix A shows that only in general medicine and general surgery are there at present sufficient consultants to staff a hypothetical network of district general hospitals each serving 100,000–150,000 population with teams of two consultants in each in-patient specialty. We are aware, if only from the long waiting lists for treatment, that consultant staffing in orthopaedics and in gynaecology needs to be strengthened; and the representatives of the Royal College of Physicians agreed with us that paediatrics is another specialty that needs to be expanded, especially because of the need to bring all child patients under paediatric supervision and to develop centres for the assessment of handicapped children. But whatever expansion of consultant staffing in these specialties (and of supporting staff and services) may be justified by the potential demand, we must recognize that the available supply of suitable manpower and of training opportunities, as well as of finance, is limited: it would surely be rash to assume in current hospital planning that there will in due course be such large increases in the numbers of consultants in obstetrics and gynaecology, orthopaedic surgery and paediatrics that two of each would be available for every district general hospital serving 100,000–150,000 population. Yet we have said in paragraph 12 above that we think it essential that each district general hospital (except perhaps in the major conurbations and cities) should include a children's unit, maternity and gynaecological departments, and accident and orthopaedic departments. It follows that we must think of considerably fewer district general hospitals each serving (on average) a considerably larger population. Indeed, the larger the population to be served, the more comprehensive the range of specialties in which teams of two or more consultants can be employed.

—SUPPORTING SERVICES AND STAFF

22. Another factor pointing in the same direction is the need for efficient organization and staffing of supporting technical and other services. We are informed that for several of these (e.g. pathology, central sterile supply, laundry) studies have already shown that concentration into large units each serving 200,000 population or more would be advantageous; and we believe that as the array of supporting technical and scientific services required in hospital medicine (some of them very expensive) continues to increase and ramify it will become less and less possible to provide at smaller hospitals all the services and staff that will be required. We appreciate that it is possible to provide these services centrally to serve more than one district general hospital, but in the case of pathology at least we doubt whether such service from a distance can ever be entirely satisfactory: the optimum solution would appear to be the large district general hospital with its own service departments.

—ACCESSIBILITY

23. We recognise that if a larger population is to be served some patients (and their visitors) will have to travel longer distances to hospital; moreover, a high proportion of hospital patients, and of their visitors, are elderly and many of them cannot afford to travel by private car or by taxi, but must rely on public or ambulance transport. We recognise also that hospitals are having increasingly to rely on married women staff, many of whom only want to work part-time and most of whom must rely on public transport to get to work. We would therefore draw special attention to the need for co-ordinated planning of hospital, ambulance and public transport services, so that the district general hospital may be as accessible as possible to the public which it serves and by which it is staffed. We would also recommend that the presently very limited arrangements for giving financial assistance to those who cannot otherwise afford to visit their relatives in hospital should be sympathetically reviewed; and that arrangements should be made to provide overnight accommodation at or near the district general hospital for relatives of dangerously ill patients and for patients who may have to attend the hospital for prolonged investigation or treatment but do not require to be nursed in bed. We also discuss in paragraphs 33–39 below to what extent hospital services could be provided in small towns at a distance from the district general hospital centre: to the extent that this is feasible, ready access for the populations in and around those towns to the district general hospital becomes less important. Even so, accessibility is an obviously important constraint on the size of population which can be served from one district general hospital.

—MANAGEMENT OF THE HOSPITAL

24. We recognise the fear that district general hospitals serving larger populations may be more difficult to manage. Such hospitals (even though including full provision for geriatrics and psychiatry) will not necessarily include many more beds than those planned hitherto, for with the development of the community services and of out-patient and day-patient treatment at the district general hospital it should be possible to make much more intensive use of the beds provided. But the diagnostic and treatment services required will be increased in proportion to the larger population served, and by the fuller integration of the hospital geriatric and psychiatric services; and allowance must be made for the continuing development of scientific medicine. It must also not be forgotten (see para. 42) that those working in the community health services will increasingly rely on the district general hospital for technical support (especially in the testing of pathological specimens). So the district general hospital of the future will undoubtedly be a larger and more complex organization, in which it may be difficult to maintain good internal communication and morale. In our view, however, this can be overcome by the development of a well-designed management structure within the hospital, and particularly within the two largest professions employed there as already recommended in the Salmon* and "Cogwheel"† Reports respectively.

—SITES

25. It has also been suggested to us that few sites really suitable for large and

* Report of the Committee on Senior Nursing Staff Structure, H.M.S.O., 1966.
† First Report of the Joint Working Party on the Organization of Medical Work in Hospitals, H.M.S.O., 1967.

comprehensive district general hospitals such as we envisage are available in the urban areas where district general hospitals are needed. We recognise that where the site at present available is inadequate for a district general hospital of the size we have in mind and cannot be enlarged, a balance will have to be struck between reducing the population to be served (and thus either the level of consultant cover or the comprehensiveness of service), building more densely (at greater cost), putting some part of the hospital off-site, and finding a larger (and no doubt more expensive or less accessible) site elsewhere: each will have its disadvantages, so the decision will not be easy. We would however recommend that really vigorous efforts be made, including where necessary purchase by agreement some years in advance of requirements and/or the use of the Secretary of State's compulsory purchase powers, to extend available sites and to acquire new ones where needed.

—CONCLUSION

26. We have discussed above the main factors bearing on the size of population for which district general hospitals should be planned. It will be for the Department and the Regional Hospital Boards to take account of these in the actual planning of the service, but it is our view that district general hospitals in the larger cities and conurbations (if adequate sites can be found) could each serve 300,000 or more people, and that most district general hospitals should be planned to serve at least 200,000.

27. A study prepared for the Committee showed that only quite a small proportion of the population would not be within reasonable distance of a district general hospital centre. Nevertheless, we accept that in the more sparsely populated areas of the country there will have to be some compromise between specialist staffing and accessibility: we have examined the pattern of district general hospitals at present planned for several such areas and we accept that in some places it will remain necessary to provide a district general hospital to serve less than 150,000 people, and in a very few places even less than 100,000. But we must emphasise the problem of staffing such smaller hospitals to an adequate professional standard: not only will it be difficult at consultant level to overcome the disincentive of professional isolation and lack of readily available cover for absence, but for trainee doctors and nurses it will be difficult to provide training of a quality and variety adequate to merit recognition by the Royal Colleges, the Universities, the General Nursing Council and the Central Midwives Board. We think it may prove necessary to make special arrangements to attract medical staff of adequate quality, e.g. by providing for the consultants to have weekly sessions at neighbouring larger district general hospitals and for registrars to rotate between the small hospital and its larger neighbours (in which case the provision of adequate residential accommodation at both will be essential). In so far as junior medical and nursing staff cannot be supplied on rotation in this way, and in so far as nurse training cannot be provided, it may be necessary to rely largely on qualified staff resident in the area (e.g. general practitioners and other doctors and nurses already working in the community health services, and married women doctors and nurses available for employment). No district general hospital will be completely independent (see para. 30 below), but the smaller the population served the greater will be the hospital's dependence on other district general hospitals. We have indeed considered

whether the term "district general hospital" should be limited to those serving not less than a certain size of population, those serving smaller populations being designated "satellite hospitals"; but any such discrimination would be arbitrary at the margin, and might increase the difficulty of staffing the smaller hospitals, so we do not recommend it.

RANGE OF ACUTE SPECIALTIES TO BE INCLUDED

28. The 1962 Hospital Plan* cited radiotherapy, neurosurgery, plastic surgery and thoracic surgery as examples of specialties which need a large catchment area than that of one district general hospital and would therefore be provided at selected district general hospitals only. We agree, but have gone into the matter more deeply.

29. We have considered with representatives of the Royal Colleges of Physicians and of Surgeons which of the medical and surgical specialties require separate staffing at consultant level and which can rather be regarded as special interests which it would be appropriate for one or two of the general physicians or general surgeons at the district general hospital to undertake (though at regional centres there may be consultants specialising wholly in them). They felt that the following specialties fall into this latter category:

Special interests within general medicine:	Cardiology
	Thoracic medicine
	Gastro-enterology
	Endocrinology
	Nephrology
	Communicable disease
	Rheumatology
Special interests within general surgery:	Paediatric surgery
	Thoracic (other than cardiac) surgery
	Peripheral vascular surgery
	Urology

No doubt other special interests within general medicine and general surgery will emerge. In order to allow this sub-specialisation to develop within the district general hospital team, we think it desirable that there should be not less than six general physicians and six general surgeons at each district general hospital; this of course reinforces our view that district general hospitals should serve larger populations (para. 26).

30. We consider that all the remaining acute specialties need to be separately staffed, by teams of not less than two consultants each with their in-patient work concentrated at one district general hospital. We have already mentioned in paragraphs 12 and 21 those acute specialties (in addition to general medicine and general surgery) in which we consider it essential that each district general hospital serving a defined population should provide an in-patient service. As for the rest, the figures in Appendix A show that in none of them could an in-patient service, staffed as we recommended, be provided at each even of the larger district general hospitals which we are recommending; representatives of

* Ibid., para. 2.

the Royal Colleges of Physicians and of Surgeons agreed with us that, in particular, in-patient provision for ear, nose and throat surgery, ophthalmology, dermatology and neurology should be made at selected district general hospitals only. Similar arguments apply to specialised dentistry and orthodontics. We would therefore emphasise the importance of planning all these services, as well as those already recognised as regional specialties (see para. 28 above), on an area or regional scale.

31. Similarly, there will be special units for particular forms of medical or surgical treatment (e.g. intermittent dialysis, treatment of burns, treatment of poisoning, treatment of tetanus) which can only be provided at selected district general hospitals (or, in the case of smallpox isolation units, elsewhere), and likewise need to be planned on an area or regional scale.

SMALL HOSPITALS IN PERIPHERAL TOWNS

32. The 1962 Hospital Plan* said:

> "The district general hospitals will provide (apart from psychiatric and regional specialties) the great majority of the beds which are needed, and as they are developed a large number of the existing small hospitals will cease to be needed. This is implicit in the new pattern and indeed is part and parcel of the improvement of the service for hospital patients. But many small hospitals will still be needed. Some will be retained as maternity units, though any additional provision will nearly always be at the district general hospital. Others will provide long-stay geriatric units. Others again, where a local population is remote or inaccessible, or where isolated towns receive an exceptional seasonal influx of visitors, will continue to admit medical emergencies which do not require specialist facilities. Finally, though this is not indicated in detail in the plan, many small hospitals where no beds, or at least no acute beds, need eventually be retained will be suitable for providing out-patient services."

33. We do not think there is any good case for retaining small hospitals in places from which it is easy to reach the district general hospital; such communities will be served better by providing comprehensive hospital facilities (including facilities for the general practitioners to take part in the hospital treatment of some of their own patients—see para. 44) at the district general hospital centre. Nor should all the small hospitals in places remote or inaccessible from the district general hospital centre be retained; many of these are under-used even now, and are not accessible to a sufficient population to justify their retention for any purpose. But there are many peripheral country towns (including some which up to now have been intended as future district general hospital centres, but which do not serve so large a population as we consider necessary for that) which in our view could sustain a hospital unit of the type outlined below.

34. In our view the essence of such a unit is that it should not attempt to provide a complete hospital service to its community, but only those hospital services which can with reasonable economy of skilled manpower (and of money) be provided locally. We have already explained (paras. 20–21) why it

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* Ibid., p. 7 at para. 25.

could not be right to maintain in-patients under the direct care of consultants in such units. Nor would it be reasonable to employ junior hospital medical staff, who are supposed to be under supervision and training by consultants, as resident medical staff in such units. It follows that the day-to-day medical cover must be provided wholly by the local general practitioners, with only such help from the specialist staff at the district general hospital as can be given at a distance (e.g. reports on X-rays and pathological specimens) or on occasional visits (for which appropriate allowance should be made in their contracts).

35. This must severely limit the scope of the in-patient work that can be undertaken in these peripheral hospital units. Mainly it should be the continued in-patient care of local patients who have already been assessed and treated by a consultant at the district general hospital, and who in the consultant's judgment no longer needs specialist medical attention but still need nursing beyond what can be provided in the community; in such a case the consultant and the general practitioner might agree that the patient should be transferred to the peripheral hospital unit under the day-to-day care of the general practitioner but under supervision by the consultant (who would visit for the purpose), or they might agree that the general practitioner should assume complete responsibility just as if the patient were being discharged to his own home.

36. We stress the importance of agreement between consultant and general practitioner on such decisions; this is even more important if there are to be any direct admissions, to a peripheral hospital unit. We were at first minded to recommend that there should be no direct admissions to such a unit, however remote from the district general hospital; but in face of views expressed in the Standing Medical Nursing, and Standing Maternity and Midwifery Advisory Committees we are prepared to accept that in remote areas some direct admissions may be allowed, provided that these fall within categories agreed in advance between the general practitioners and the consultants concerned (as is often already the practice in general practitioner maternity units). These categories, whether for maternity or for medical cases, should be drawn so as to include only those conditions with which the staff and other facilities of the peripheral hospital unit can be expected to cope: in effect these will be only such conditions as the general practitioner and the district nurse could deal with in the patient's own home if his home conditions were good enough.

37. For nursing staff, the peripheral hospital unit will have to rely on locally resident trained nurses and auxiliaries, but these should be placed under the supervision of the senior nursing staff at the district general hospital as recommended in the Salmon Report.* Indeed, the whole unit should be regarded as no more than an outpost of the district general hospital; it is for this reason that we use the term "peripheral hospital unit", rather than "peripheral hospital".

38. We have considered to what extent day-patient and out-patient facilities should be provided in association with the in-patient facilities of the peripheral hospital unit. We readily accept that it will be convenient if a group of the local general practitioners have their practice premises on the site, and even more so if these are associated with other domiciliary and community health and welfare

* Op. cit.

services in a health centre alongside the peripheral hospital unit. It is doubtful, however, to what extent it would be economic to bring consultants and other specialist staff from the district general hospital to conduct a day hospital and out-patient clinic in such a peripheral centre; we think this needs further study (see also para. 42 below).

39. We appreciate that what we have said in the preceding paragraphs will disappoint many of those who work in, and of those who are served by, existing small hospitals and who are naturally proud of them. We do believe however that it is only by accepting a limited role complementary to, rather than competitive with, that of the district general hospital that small hospitals can justify their survival. If this limited role is accepted, however, we consider that there is justification for retaining small hospitals in the peripheral country towns; indeed we regard this as an essential corollary of our recommendation that there should be fewer district general hospitals.

RELATIONSHIP WITH GENERAL PRACTITIONERS AND OTHER COMMUNITY SERVICES

40. We have already referred (para. 11) to the interdependence of hospital and community health services (including those provided by general practitioners): the best use will be made of specialised and expensive hospital facilities only if the community-based services are seen to be capable of providing effective community care when hospital care is not really required. It is therefore essential to plan these services together, not separately.

41. This can be exemplified in relation to the prevention of disease. Thus the role of the hospital in setting a good example in such aspects of primary prevention as the control of cigarette smoking can have a direct effect on local attempts at health education of the public; in the case of secondary prevention (i.e. early diagnosis), the diagnostic and treatment services of the hospital must be in step with the application of screening techniques in the community; and the success or failure of tertiary prevention (i.e. prevention of relapse) will be determined in large measure by the efficacy of the co-ordination of continuing care between hospital and community services.

42. It appears that the basic domiciliary services of general practitioners, health visitors, social workers, home nurses, midwives and various ancillary workers are likely in future to be provided by teams which will increasingly be based on health or group practice centres, many of which will serve populations of 20,000 or more. It will often be possible to site one health centre on or adjacent to the district general hospital site; this would give the best opportunities for the co-ordination of services and for using the resulting complex of hospital and health centre for the training of all types of health service personnel. The great majority of health/group practice centres will, however, be dispersed throughout the geographical areas served by district general hospitals; at these it may be more difficult to maintain liaison with the district general hospital. It is essential that these health/group practice centres should have proper diagnostic support: some of the simpler diagnostic facilities will no doubt be provided on site, but for the rest they will need to look to the district general hospital. One possibility which should always be considered is that of holding

consultative clinics at such centres; but this will depend on how much out-patient work in the specialty arises in the area concerned.

43. It is important in any event that the domiciliary team should not feel isolated from the district general hospital. Not only is there the need to secure continuity of care in and out of hospital for individual patients, but the members of the domiciliary team should look to the hospital for much of their training and post-graduate education, whilst many members of the hospital staff would likewise benefit from periods of work in the community. A post-graduate centre for the area should normally be an integral part of the district general hospital and should cater not merely for doctors but for all health service personnel. Combined systems of training for work both in the hospital and in the community should be developed for most types of staff, and maximum use should be made of systems of secondment and of joint appointment between the hospital and community services. Only when those working in these two complementary spheres fully understand each other's problems and points of view will it be possible to provide the best possible system of care for patients.

44. General practitioners in particular should benefit from regular part-time work as members of the district general hospital team, provided that this is in some area of medicine relevant to general practice, such as general medicine, accident and emergency work, gynaecology and obstetrics, paediatrics, psychiatry or geriatrics; and we understand that in future there may be increased opportunities for general practitioners to undertake work of this kind. However, we have also considered, with the help of oral evidence from the Royal College of General Practitioners and other professional organisations concerned and of a report from the general practitioner unit at East Birmingham Hospital, the extent to which general practitioners should be offered responsibility for treating some of their own patients in the district general hospital. We recognise that not all general practitioners would in practice be able to accept this responsibility; and also that the presence of a considerable number of different general practitioners, each responsible for the treatment of only a few patients, must add to the difficulty of running the hospital. We also recognise the difficult problem of the relationship between the general practitioners and the resident junior hospital doctors, if these are to be expected to look after the general practitioners' patients; nevertheless we think it better that the general practitioner, though responsible for the treatment of his own patient, should work with the hospital doctors in the ordinary wards rather than in a ward reserved exclusively for general practitioner cases. Our view is that more experimental schemes on these lines are urgently required so that the most satisfactory arrangements may be worked out.

45. Certain of the more specialised community health services (e.g. medical/psychiatric social work, occupational therapy and some components of the school health service such as child guidance and speech therapy) are provided by personnel with qualifications similar to those of analogous hospital staff. There is therefore considerable scope for such staff to be based on the district general hospital and to work part-time at health centres or in a domiciliary setting: examples of co-ordinated schemes of this kind already exist and their further growth should be encouraged. We hope that, while the report of the

Seebohm Committee* is being considered, the importance of maintaining sufficient flexibility to permit joint hospital and community approaches to the provision of social work services will be borne in mind.

46. In view of all this, we find ourselves in favour of the idea of locating an appropriate department or office of the local health authority at the district general hospital in order to facilitate the prompt deployment of domiciliary health services for patients who are in need of them, and to help in the development of the complementary relationship which should exist between the hospital and domiciliary components of medical care. Such an arrangement would be particularly valuable, the local Medical Officer of Health or one of his senior local authority medical colleagues could hold an appropriate appointment on the staff of the district general hospital. Whatever administrative reorganisation of the National Health Service may be decided on, we consider this functional integration of the community health services with the hospital services very desirable if there is to be real and continuing consultation between those responsible for the various services, which interlock in so many ways.

TRAINING AND EDUCATIONAL FUNCTIONS

47. It is not for us to consider in detail the arrangements to be made for the basic training and education of the many professions whose members will work in the district general hospitals; we would however point out that large, comprehensive district general hospitals such as we advocate will be better able than the hospitals of today to provide comprehensive training and education for their staffs.

48. Many district general hospitals (including those formally recognised as "teaching hospitals" or "university hospitals", but not these only) will of course be engaged in the clinical training of medical students; but as already stated in paragraph 42, we think every district general hospital should be involved (in association with the appropriate university medical school and the various Royal Colleges) in the post-graduate education of its own medical staff and of all other doctors working in the area, together with the associated professions.

49. Every district general hospital should be able to support a school of nursing, offering integrated training for the general and the various supplementary Registers. The inclusion of obstetric, paediatric, geriatric and psychiatric nursing in the general training of the nurse would be in line with the current trend in nursing education which aims to provide a broad and sound foundation for later specialisation in any branch of nursing. Moreover, if the district general hospital becomes more closely integrated with the local community health and welfare services, it should be possible to give every nurse in training some experience in the preventive and curative nursing services outside the hospital. We think this broadening of nurse training should help to attract recruits.

50. We have indeed taken evidence on the question whether nurses should continue to be recruited and trained separately for psychiatric nursing. Both the General Nursing Council and the Royal College of Nursing favour the retention

* Report of the Committee on Local Authority and Allied Personal Social Services, Cmnd. 3703, July 1968.

of separate Registers, but there was support for a much closer link between all basic courses of training for the General, Psychiatric and Mental Subnormality Registers. On the organisation of psychiatric nurse training there was general agreement that students need experience in nursing both acute and long-stay patients. Where acute units in general hospitals are for the time being linked with long-stay psychiatric hospitals, the closest co-operation is needed to ensure that a broad range of experience is available to both the students and those responsible for training them; a regular interchange of staff and high standards of teaching would best be achieved if all the psychiatric services were made an integral part of the district general hospital as we propose.

51. Similarly, a fully integrated maternity service based on the district general hospital would provide the ideal setting for the training of midwives and we would expect all district general hospitals to undertake midwife training.

52. In addition to providing basic courses for registered and enrolled nurses and for midwives—and refresher courses for those returning to nursing after an interval—the district general hospital would be the centre for post-registration courses in various clinical specialties such as paediatrics, psychiatry and geriatric nursing. District general hospitals selected to undertake regional specialties such as neurosurgery or cardio-thoracic surgery, would also provide appropriate post-certificate clinical courses for nurses. Advanced courses for staff working in midwifery units would also be provided in certain district general hospitals.

53. Similarly, the district general hospital will need to provide training as well as employment for the professions supplementary to medicine and all the various grades of scientific and technical staff: we have noted with interest the Zuckerman Report* about these.

54. We would point out the need for the district general hospital to include not only lecture-rooms but also an adequate library for all the various grades of staff in training, and residential accommodation (with reasonable provision for recreation) for those who cannot be expected to find their own accommodation in the community. We welcome the recommendations of the Tunbridge Committee† on the need for an occupational health and counselling service for hospital staff, especially those trainees who are resident; the hospital chaplains could play a part in this, as well as in the care of patients.

RESEARCH

55. A number of our witnesses have emphasised the need to make time and facilities available at district general hospitals for research. We certainly agree that district general hospital staff of all professions should have opportunity to engage in research, and again we think that it would be easier to provide this in the large, comprehensive district general hospitals we envisage.

PRIVATE PRACTICE

56. Some of our medical witnesses have emphasised the need to provide for private practice. All we would say on this is that if district general hospital staff

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* Report of the Committee on Hospital Scientific and Technical Services, 1967–68, H.M.S.O., 1968.

† Report of the Joint Committee on the Care of the Health of Hospital Staff, H.M.S.O., 1968.

engage in private practice, it will be in the best interests both of their private and of their National Health Service patients that they should do so at the district general hospital (where appropriate provisions should be made) rather than at private consulting-rooms or clinics.

IMPLEMENTATION

57. We recognise that a large programme of hospital building, based on the concept of the district general hospital set out in the 1962 Hospital Plan, is already gathering way and cannot quickly be modified. We certainly would not wish to halt any projects already under construction, or to interrupt the increasing momentum of this programme. But our recommendations do imply a considerable reduction in the number of district general hospitals which should be built, and a corresponding increase in the average population to be served by each. They also imply that all plans to upgrade, develop or rebuild separate hospitals for geriatric or psychiatric patients (including the mentally subnormal) ought to be urgently reviewed, with a view to making provision for these patients in district general hospitals instead. Such radical recommendations will no doubt need careful consideration, but if they are going to be accepted, it is important that this should be done quickly, before more and more capital is committed to what we regard as an out-dated concept.

58. Those of us who serve on hospital Boards can appreciate the difficulties which Boards and the Department will face in adapting the hospital building programme to conform with our recommendations. For example, where capital has already been committed to building a district general hospital designed to serve a population in the range 100,000–150,000, the project can hardly be abandoned; but by making more intensive use of the beds provided and by expanding the other departments it may prove possible to serve a much larger population (and therefore to employ a much stronger consultant staff) than originally envisaged. Where the limited size of the site prevents such expansion, it may be possible to build an annexe nearby, or to make a functional amalgamation of two existing hospitals. Where such an expedient is unavailable, however, it should not only be geriatric and psychiatric patients who are accommodated in the annexe or subsidiary wing: we would rather see this used to accommodate patients (in whatever specialty) who have passed through the intensive phase of their treatment and are being prepared for discharge. (The peripheral hospital unit described in paragraphs 33–39 would be a special case of this.)

59. We also recognise that, other things being equal, larger district general hospitals will take longer to build, and we know how unsatisfactory it is to work in a hospital whose construction is not yet complete. But we believe that it will be possible to speed up the process of design and construction by adopting standardised designs and industrialised methods of building; indeed we think this necessary even for the execution of the present hospital building programme.

60. Even where capital has not yet been committed, it will require a great effort to modify or abandon plans which may have been in preparation for many years, and to which hospital Boards and the Department may have become publicly committed; and to convince the public that such changes are justified. We can only say that we think this effort ought to be made, and that given the necessary resolve we believe the difficulties may not prove quite so intractable as they appear.

Summary of Principal Recommendations

(1) Interdependence and need for joint planning of the hospital and the community health services (paras. 11 and 40–46).

(2) No further development of separate hospitals for any single acute specialty (para. 11).

(3) All hospital psychiatric (including mental sub-normality) and geriatric treatment to be based on district general hospitals; existing hospitals in these specialties to be run down and closed (paras. 14 and 16).

(4) District general hospitals should be planned around teams of not less than two consultants in each specialty, with all their in-patients at the one district general hospital (para. 20).

(5) Most district general hospitals should therefore be planned to serve at least 200,000 population each, and up to 300,000 or more in the major concentrations of population (para. 26).

(6) Importance of making the district general hospital as accessible as possible to its public (para. 23).

(7) Where geography makes it essential to plan a district general hospital to serve substantially less than 200,000 population, special consideration will have to be given to how the hospital is to be staffed (para. 27).

(8) In-patient provision for e.n.t. surgery and ophthalmology should be made at selected district general hospitals only (para. 30).

(9) Small hospitals in some peripheral country towns to be retained as "peripheral hospital units", but in a limited role (paras. 33–39).

(10) General practitioners to be offered part-time work in relevant specialties at the district general hospital, perhaps including responsibility for the care of some of their own patients, but as members of the hospital team (para. 44).

(11) Integration of nurse training (para. 49 et seq).

(12) Need for review of the hospital building programme (paras. 57–60).

APPENDIX A

Consultant staffing of the acute specialties

Specialty	*Number of consultants*[1]	*Population*[2] *per two consultants* ('000)
General medicine[3]	1,337	72
Dermatology	160	605
Venereal diseases	85	1,139
Neurology	101	958
Paediatrics	256	378
General surgery[4]	948	102
Ear, nose and throat	306	316
Ophthalmology	335	289
Traumatic and orthopaedic surgery	467	207
Plastic surgery	62	1,561
Thoracic surgery	99	978
Neurosurgery	72	1,344
Radiotherapy	165	587
Gynaecology and obstetrics	537	180
Dental surgery	260	372
Orthodontics	66	1,466

Notes: 1. Whole-time, part-time and honorary, at 30th September, 1967, in England and Wales.

2. Estimated home population of England and Wales at 30th June, 1967 (49,390,800).

3. Including rheumatology, infectious diseases, diseases of the chest, cardiology.

4. Including urology.

Sources: Ministry of Health Annual Report for 1967, Table 63, part 2. Registrar General's Annual Estimates of the Population for 1967.

APPENDIX B

List of bodies and individuals who gave written (* and oral) evidence

Dr. D. J. B. Ashley (Consultant Pathologist, Morriston Hospital, Swansea)
Association of Anaesthetists of Great Britain and Ireland
*Association of Hospital Management Committees
Association of Hospital Matrons
Association of Hospital and Welfare Administrators
Association of Municipal Corporations
Association of Occupational Therapists
Austin Knight Limited
Birmingham Regional Hospital Board
Borough of Ilkeston
British Association of Dermatology
British Association of Otolaryngologists
British Association of Paediatric Surgeons
British Association of Physical Medicine
British Association of Urological Surgeons
British Cardiac Society
British Dental Association
*British Geriatrics Society
British Institute of Radiology
British Medical Association (various Committees and Groups)
British Orthopaedic Association
British Paediatric Association
British Tuberculosis Association, Joint Tuberculosis Committee
Central Middlesex Hospital Medical Committee
*Central Midwives Board
Chartered Society of Physiotherapy
Claybury Hospital Medical and Nursing Staff
College of Pathologists
Council for Professions Supplementary to Medicine
County Councils Association
Dr. G. H. Dobney (Consultant in Physical Medicine, Whittington Hospital)
East Anglian Regional Hospital Board
Executive Councils' Association (England)
Faculty of Dental Surgery of the Royal College of Surgeons
Faculty of Ophthalmologists
Faculty of Radiologists
*General Nursing Council for England and Wales
Guild of Public Pharmacists
Mr. N. H. Harris (Consultant Orthopaedic Surgeon, Paddington General Hospital)
Health Visitors' Association
Herefordshire Executive Council
Institute of Hospital Administrators
Institute of Medical Social Workers
Joint Committee of the Churches

King Edward's Hospital Fund for London
Leeds Regional Hospital Board
Leicester Consultants and Specialists
Littlemore Group Hospital Management Committee
Liverpool Regional Hospital Board
Manchester Regional Hospital Board
Medical Practitioners' Union
National Association of Hospital Management Committee Group Secretaries
National Old People's Welfare Council
Newcastle Regional Hospital Board
North East Metropolitan Regional Hospital Board
North West Metropolitan Regional Hospital Board
Oxford Regional Hospital Board
Pembroke County War Memorial Hospital Medical Staff
Professor Desmond Pond, Department of Psychiatry, The London Hospital Medical College
Queen's Institute of District Nursing
Regional Hospitals' Consultants and Specialists Association
*Royal College of General Practitioners
*Royal College of Midwives
*Royal College of Nursing
*Royal College of Obstetricians and Gynaecologists
*Royal College of Physicians of London
*Royal College of Surgeons of England
*Royal Medico-Psychological Association
Rural District Councils Association
*Senior Administrative Medical Officers of Regional Hospital Boards
Sheffield Regional Hospital Board
Society of British Neurological Surgeons
*Society of Medical Officers of Health
Society of Thoracic Surgeons of Great Britain and Ireland
South West Metropolitan Regional Hospital Board
South Western Regional Hospital Board
Teaching Hospitals Association
Welsh Hospital Board
Wessex Regional Hospital Board
West Middlesex Hospital Consultants

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